TRICARE LATIN AMERICA & CANADA (TLAC) PRIME ENROLLMENT APPLICATION (Puerto Rico Version)

SPONSOR INFORMATION

CAN BE COMPLETED BY ANY ADULT BENEFICIARY. SEE REVERSE FOR DIRECTIONS. PLEASE PRINT CLEARLY.

1. Sponsor Name (last, first, middle initial)	2. Sponsor Social Security Number	3. Sex	4. Country Sponsor Residing in:	5. Date of Birth (dd/mmm/yyyy)	6. Rank	7. Telephone Numbers
						Home: (787)
						Duty: ( )

8. Duty Address (Unit, Office Symbol, Station, APO/FPO)	9. Unit Identification Code	10. Mailing Address in Puerto Rico	11. Sponsor Branch of Service (Must be Active Duty)		
			Army	Air Force	Navy
			Marines	USCG	NOAA/PHS

12. E-Mail Address (if available) Please Print Clearly	13. Active Duty Primary Care Manager (PCM)/MTF Selection (Please check one)		
	☐ Naval Hospital Roosevelt Roads (NHRR)	☐ Ramey Clinic, Borinquen (Active Duty Only) (RCB)	**Enter PCM Name for Active Duty Sponsor:** (Enter City for Remote Puerto Rico)
	☐ Rodriguez Army Health Clinic, Fort Buchanan (RAHC)	☐ San Juan Base, Sick Bay (Active Duty Only) (SJSS)	
	☐ Branch Clinic Sebana Seca, (BCSS)	☐ Remote Puerto Rico (RemPR)	

FAMILY MEMBER INFORMATION

LIST ALL FAMILY MEMBERS WHO ACCOMPANIED THE SPONSOR TO PUERTO RICO AND ARE APPLYING FOR ENROLLMENT. PLEASE PRINT CLEARLY

14. Family Member Name (last, first, middle initial)	15. Family Member's Social Security Number	16. Sex (M or F)	17. Relationship to Sponsor	18. Date of Birth (dd/mmm/yyyy)	19. Residing in Puerto Rico?	20. Family Member PCM Selection
					Yes / No	(*Enter MTF and Provider's Name*)
					Yes / No	(*Enter MTF and Provider's Name*)
					Yes / No	(*Enter MTF and Provider's Name*)
					Yes / No	(*Enter MTF and Provider's Name*)
					Yes / No	(*Enter MTF and Provider's Name*)
					Yes / No	(*Enter MTF and Provider's Name*)

21. SIGNATURE: "I have read the instructions on the reverse side of this form and understand the Privacy Act Statement listed there. I further request enrollment for my listed family members in TRICARE Latin America & Canada Prime."

SIGNATURE DATE

(Rev. May 2000)

Please return this completed application to the TRICARE Service Center nearest you or the TLAC Support Office (details on back)

INSTRUCTIONS

1. SPONSOR NAME. Last name, first name, middle initial.
2. SPONSOR SOCIAL SECURITY NUMBER. This is the SSN of the active duty member
3. SEX. M or F.
4. SPONSOR RESIDING IN: Country in which the sponsor is stationed.
5. DATE OF BIRTH. Enter DOB of sponsor. List by dd/mmm/yyyy (example: 11 Oct 1962).
6. RANK. List rank of sponsor (not pay grade). (example: Army 0-4 should be MAJ).
7. TELEPHONE NUMBER. Sponsor's work & home phone numbers.
8. DUTY ADDRESS. Please list Unit, Office Symbol, Installation, APO/FPO, Zip Code (Please include the actual country you work in, i.e. Cuba, Paraguay, Canada, etc.)
9. UNIT IDENTIFICATION CODE. Enter the sponsor's UIC.
10. MAILING ADDRESS. This is your mailing address in Puerto Rico where you currently reside. Include PSC, Box Number, APO and Zip Code.
11. **SPONSOR BRANCH OF SERVICE:** Circle the appropriate selection.

    Note: **Currently, only Active Duty and their family members are authorized to enroll in TLAC Prime.**
12. E-MAIL ADDRESS: Please provide if one exists for work, home or both. (This will provide another avenue for important medical benefit information to be distributed)
13. PRIMARY CARE MANAGER (PCM) SELECTION.

    If you have any questions please contact the nearest TRICARE Service Center.
14. FAMILY MEMBER NAME. List each family member (last name, first name, middle initial) who accompanied the sponsor to Puerto Rico, is listed on the sponsor's original orders, and/or who will reside in Puerto Rico.
15. FAMILY MEMBER SOCIAL SECURITY NUMBER. Please list the Social Security Numbers for each family member. If the family member has not yet been issued a SSN, write that in this section. If you do not know the number, please write UNKNOWN in this block.
16. SEX. Please enter the Family Member's Sex (M for male or F for female)
17. RELATIONSHIP TO SPONSOR: Please enter the appropriate response using the samples below (For questions please contact the TLAC Support Office):
    - SPOUSE
    - DAUGHTER
    - SON

**** IF SPOUSE IS ALSO ON ACTIVE DUTY, PLEASE INDICATE IT IN THIS BLOCK****

18. DATE OF BIRTH. List the date of birth for each family member.
    (dd/mmm/yyyy) i.e. 01 Jan 1960
19. CURRENTLY RESIDING IN PUERTO RICO. Circle appropriate response.
20. SELECT A PCM FOR EACH FAMILY MEMBER. If living remotely in Puerto Rico you may choose to enroll to a MTF PCM or use a remote network provider. Contact the nearest TSC for more information. **See Prime enrollee Healthcare Passport for beneficiary cost information concerning use of network/non-network providers in Puerto Rico.**
21. SIGNATURE. Either adult beneficiary must sign and date the form. The signature of the sponsor or the sponsor's spouse is required.

Mail or deliver completed forms to the nearest TRICARE Service Center at Rodriguez Army Health Clinic, Fort Buchanan or Naval Hospital, Roosevelt Roads

Or mail to: TRICARE Latin America & Canada Support Office
P.O. BOX 7380
Fort Gordon, GA 30906-9800
OR FAX to: (706) 787-3024 (DSN: 773)
OR E-mail completed form (as attached file) to **tricare15@se.amedd.army.mil**

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10, USC, Sec. 1095 and 1099; EO 9397
PRINCIPAL PURPOSE(S):	Information will be used to enroll the beneficiary(ies) in TRICARE Latin America & Canada Prime, and to assign Primary Care Managers (PCMs) to each enrollee. Information will also be used by military treatment facility (MTF) staff and TRICARE contractors to determine eligibility for care and payment of claims.
ROUTINE USE(S):	The information on this form will be released to the MTF staff, TRICARE contractors, and providers of health care.
DISCLOSURE:	Is voluntary, however, failure to provide the information requested may preclude your enrollment in TRICARE Latin America & Canada Prime.